Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Re-Evaluation of the Quality Management Program at the Marion VA Medical Center Marion, Illinois

Report No. 10-03640-02

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VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed a re-evaluation of the quality management (QM) program at the Marion VA Medical Center (the facility), Marion, IL. The purposes of the evaluation were to determine whether the facility had a comprehensive, effective QM program designed to monitor patient care activities and whether the facility was in compliance with selected components of provider credentialing and privileging (C&P).

The results of this re-evaluation indicated substantial improvement in the QM and selected C&P areas cited for noncompliance in reviews conducted by the OIG in 2008 and 2009. Current senior leaders have implemented and supported a comprehensive QM program that will enable staff to raise issues to their attention, and the facility performed ongoing reviews and analyses of all areas assessed. Facility senior managers reported that they were actively involved in reviewing QM information. The facility's C&P processes appeared to be in current compliance. The individualized discussion of providers' performance data at reprivileging was a strong positive practice. We made no recommendations.

The Veterans Integrated Service Network 15 Director concurred with our conclusions.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Veterans Integrated Service Network 15 Director (10N15)

SUBJECT: Healthcare Inspection – Re-Evaluation of the Quality Management Program at the Marion VA Medical Center, Marion, Illinois

Summary

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed a re-evaluation of the quality management (QM) program at the Marion VA Medical Center (the facility), Marion, IL. The purposes of the evaluation were to determine whether the facility had a comprehensive, effective QM program designed to monitor patient care activities and whether the facility was in compliance with selected components of provider credentialing and privileging (C&P).

The results of this re-evaluation indicated substantial improvement compared with evaluations conducted by the OIG in 2008 and 2009. We found that the facility had established a comprehensive QM program and performed ongoing reviews and analyses of the mandatory areas assessed. We also found that the facility was in compliance with selected components of provider C&P.

Background

Since the early 1970s, VA has required its health care facilities to operate comprehensive QM programs to monitor the quality of care provided to patients and to ensure compliance with selected VA directives and accreditation standards. One important component of QM is the proper C&P of providers.

In 2007, the Under Secretary for Health and Congress asked the OIG to perform a comprehensive review of the facility as a result of concerns about high mortality rates, the quality of surgical care, and deficiencies related to QM processes and C&P. This review concluded that the facility's ability to effectively respond to quality of care concerns was hampered by an ineffective QM program.[1]

[1] *Healthcare Inspection – Quality of Care Issues, VA Medical Center, Marion, Illinois*, Report No. 07-03386-65, January 28, 2008.

In 2009, the OIG conducted a Combined Assessment Program (CAP) review at the facility and again identified problems with the QM program and C&P.[2] Findings in five QM program areas and two C&P aspects were similar to findings from the 2007 review, indicating lack of improvement.

Scope and Methodology

We made an unannounced visit to the facility August 24–26, 2010. Our review focused on the QM program and selected C&P activities over the 6-month period from February through July 2010. To evaluate QM activities, we interviewed the facility's Director and Chief of Staff, selected service chiefs, and QM personnel, and we reviewed plans, policies, and other relevant documents. We did not evaluate the actual quality of care provided. To evaluate C&P activities, we reviewed C&P files and provider profiles for a sample of 27 providers, and we assessed the plan, criteria, and data for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). We also reviewed committee meeting minutes where C&P was discussed.

We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: QM Program

A. Program Areas

QM Committee. The Veterans Health Administration (VHA) requires an organized, systematic approach to planning, delivering, measuring, and improving health care.[3] The facility had established a senior-level committee with responsibility for QM and had created a structure for communication of QM results to that committee. Also, the facility had implemented a standardized format for meeting minutes and a consistent method to keep track of open agenda items. The committee structure, meeting minutes, and tracking method appeared to provide an effective mechanism for senior managers to be aware of QM results throughout the organization. This conclusion represents a substantial improvement from the previous reviews that identified fragmented, dysfunctional committees.

Mortality Analysis. VHA requires the trending of mortality data to identify suspicious events.[4] Deaths are to be trended by ward, service line, shift, time, and provider. We

[2] *Combined Assessment Program Review of the Marion VA Medical Center, Marion, Illinois*, Report No. 08-03083-17, November 2, 2009.
[3] VHA Directive 2008-061, *Quality Management Program*, October 7, 2008 (reissued as VHA Directive 2009-043, *Quality Management System*, September 11, 2009).
[4] VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.

found that deaths were reviewed and that mortality data was trended and reported adequately in several committees' meeting minutes. This conclusion represents an improvement from the previous reviews that identified inconsistent review and reporting of deaths and inadequate mortality analyses.

Peer Review Management. VHA requires a process for initiating, conducting, and documenting peer review for QM.[5] The facility's Peer Review Committee submitted quarterly reports to the Clinical Executive Board (CEB). Follow-up items and recommendations from peer reviews were analyzed for trends, and peer reviews were completed within the required timeframes. The facility's current process represents a substantial improvement from the previous reviews that identified untimely peer review completion and inadequate communication of identified issues.

Adverse Event Disclosure. VHA facilities have an obligation to disclose adverse events to patients who have been harmed in the course of their care, for example, as a result of significant medication errors.[6] The facility had a consistent process in place to evaluate adverse events for disclosure. This current process represents an improvement from the previous reviews that identified inconsistent decision criteria and delays in disclosure.

Patient Safety. VHA requires facilities to have comprehensive patient safety programs that encompass reporting and analyzing patient incidents and conducting proactive safety assessments.[7] We found that the facility's root cause analyses were completed within the required timeframe and included clear action plans when indicated. Tracking mechanisms appeared to be effective in ensuring that actions were completed and evaluated to determine whether they achieved the expected results. The Patient Safety Manager described a process that encourages staff to identify and report patient incidents throughout the facility. Patient safety reports that included timeliness, alerts and advisories, and action tracking had been presented to appropriate committees with adequate frequency. The facility's current patient safety program represents an improvement from the previous reviews that identified a lack of integration and inconsistent incident reporting and action tracking.

Medical Records. VHA requires systematic review of the quality of entries in patients' medical records.[8] We found that medical record quality had been reviewed regularly for timeliness, accuracy, and completeness and that opportunities for improvement had been identified. Copy and paste use had been monitored, as required. The facility's current process represents an improvement from the previous reviews that identified a lack of regular medical record reviews and trending and reporting of results.

[5] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[6] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[7] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[8] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Operative and Other Procedures Review. Moderate sedation is used to increase the comfort of patients undergoing procedures and diagnostic treatments. VHA requires monitoring of moderate sedation outcomes, including reporting and trending the use of reversal agents (medications used to reverse sedation effects that were deeper than anticipated).[9] We found that complications data were critically analyzed and compared with benchmarks and that the use of reversal agents was monitored. Although no problems had been identified, we concluded that a process was in place that would enable staff to raise issues to the attention of senior leaders. The facility's current process represents an improvement from the previous reviews that identified a lack of moderate sedation data analysis.

Review of Resuscitation and Life Support Training. VHA requires that resuscitation data be collected and critically analyzed.[10] We found that the facility collected and critically analyzed its resuscitation data and that the results were compared with benchmarks. As problems or issues were identified, they were addressed with action plans. VHA expects that each facility will have a policy that defines the staff who need to have current cardiopulmonary resuscitation (CPR) or Advanced Cardiac Life Support (ACLS) training, a mechanism to ensure compliance, and consequences if needed training is not maintained.[11] We found that the facility's policy identified the staff who require CPR and ACLS training and that designated staff were current at the time of our visit. The facility's current life support training process represents an improvement from the previous CAP review that identified a vague policy and staff who had not received required life support training.

Utilization Management. Utilization management (UM) is the process of evaluating and determining the appropriateness of medical care services to ensure the proper use of resources. VHA implemented a standardized system-wide UM approach in 2005.[12] We found that the facility's UM reviewers had been trained and had completed reliability testing. UM reviewers collaborated with the interdisciplinary patient care teams during daily "bed huddles." UM reviewers and the physician UM advisor had an electronic method to communicate. UM data were analyzed, and results were compared with goals. Although no systems problems had been identified, we concluded that a process was in place that would enable staff to raise issues to the attention of senior leaders. The facility's current UM program represents an improvement from the previous CAP review that identified inconsistent review and data analysis.

System Redesign. In 2006, VHA implemented a system-wide structure, known as "system redesign," to support the study and improvement of patient flow. We found that

[9] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[10] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[11] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[12] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

the facility had identified opportunities to improve patient flow and had implemented appropriate action plans and tracking mechanisms. A plan for delivery of care to patients in temporary bed locations was in place, as required. System redesign data analysis and action tracking were included in the overall QM program and reported to appropriate committees. The facility's current system redesign efforts represent an improvement from the previous CAP review that identified inconsistent data analysis and lack of action evaluation.

We also reviewed two additional components of a comprehensive QM program and found them to be in compliance. These areas (listed below) were not cited as deficient in the two previous reviews.

- Patient Complaints
- Medication Reconciliation

B. Senior Managers' Support for QM Efforts

Facility directors are responsible for their QM programs, and senior managers' involvement is essential to the success of ongoing QM efforts. During our interviews, senior managers voiced strong support for QM efforts. They stated that they were involved in QM in the following ways:

- Chairing or attending executive-level committee meetings
- Reviewing meeting minutes
- Chairing the Peer Review Committee (Chief of Staff)
- Reviewing patient safety analyses

The Acting QM coordinator agreed that senior managers and clinical staff supported the program.

Issue 2: C&P

Credentialing is the process by which facilities screen and evaluate providers' licensure, education, relevant experience, and current competence. Privileging is the process by which each facility determines what procedures or services an individual provider may perform at that facility based on specific clinical competence as well as the needs and capabilities of the facility. Privileges must be facility specific and must only be granted for activities actually performed at a given facility. Competence is evaluated initially and on an ongoing basis. Criteria are specified in advance, and performance data are maintained in provider profiles. Every 2 years, all providers are re-evaluated and considered for reprivileging.[13]

[13] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

We reviewed the C&P files and profiles of a sample of 27 providers. We also reviewed Professional Standards Board (PSB) and CEB meeting minutes where C&P was discussed. We found that all providers reviewed had current licenses and that primary source verification had been obtained, as required. Privileges granted appeared to be consistent with the facility's current scope of services. We found adequate FPPEs for the seven physicians in our sample who had been newly hired. We found that the OPPE process had evolved and that recent efforts provided adequate performance data to meet current requirements. Although service-specific criteria had been developed by service chiefs and approved by the Chief of Staff, they had not been presented to and approved by the facility's medical staff. The Chief of Staff agreed to remedy the situation; therefore, we made no recommendation. The facility's current C&P processes represent an improvement from the previous reviews that identified insufficient performance data, inappropriate privileges, and inadequate documentation of PSB discussions. We found such excellent documentation in recent PSB meeting minutes—showing detailed discussion of each individual provider's performance data at reprivileging—that we would suggest VHA use this model as an example.

Conclusions

We found substantial improvement in the QM and selected C&P areas cited for noncompliance in the two previous reviews. Current senior leaders have implemented and supported a comprehensive QM program that will enable staff to raise issues to their attention, and the facility performed ongoing reviews and analyses of all areas assessed. Facility senior managers reported that they were actively involved in reviewing QM information. The facility's C&P processes appeared to be in current compliance, and FPPE and OPPE were adequate. The individualized discussion of providers' performance data at reprivileging was a strong positive practice. We made no recommendations.

Comments

The Veterans Integrated Service Network 15 Director concurred with our conclusions. (See Appendix A, page 6, for the full text of the comments.)

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 24, 2010

From: Director, VA Heartland Network (10N15)

Subject: **Healthcare Inspection – Re-Evaluation of the Quality Management Program at the Marion VA Medical Center, Marion, Illinois**

To: Assistant Inspector General for Healthcare Inspections (54)

I have reviewed the Re-Evaluation of the Quality Management Program report conducted at the Marion VA Medical Center and concur with the conclusions outlined in the report.

(original signed by:)
JAMES R. FLOYD, FACHE

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous Director, Combined Assessment Program (310) 729-9466
Acknowledgments	Dorothy Duncan Toni Woodard

Appendix C

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